Hanford Employee Welfare Trust

CHANGE REQUEST FOR MEDICAL COVERAGE Retirees - Calendar Year 2022

Complete and return this form by 11/04/21 **ONLY** if:

- you wish to change to another available retiree medical plan for 2022; and/or
- you wish to make changes for the eligible dependents you have enrolled
- you wish to use your one-time re-enrollment option, from Deferred Medical status
- if you wish to defer your coverage for 2022 (one time option only)

Retiree/Surviving Spouse	Name: (Las	t, First, MI)		
Social Security No.:		Street/PO Box Addre	SS	
City:	State:	Zip Code:	Check here	if new address:[]
Telephone:	I	Email Address:		
Medical Plan Selection ONLY IF YOU ARE MAKING A CHANGE				
Permanente for service [] Defer coverage for yo	edical Plan and eligible de ealth Plan of and eligible de area information ou and your e	pendents Washington Options, Inpendents residing in the Kaion)	ser Permanente servicent(s) for 2022	
		My Enrolled Dependent		
*Note: Once a dependent is	s deleted, the	y cannot re-enroll at a la	ter date.	
Please make the following	change for r			•
Dependent Name (Last, First, Other Reason for Change:				[] Delete from coverage [] Other (explain below)
Retiree/Surviving Spouse Date:	_			
Return completed form to	c/o HMI PO Box	d Employee Welfare Tru IS – Benefits Administra 943, H2-23 d, WA 99352		nistration

BEFORE MAILING, MAKE A COPY OF THIS FORM FOR YOUR RECORDS